

**COUNSELING INSTITUTE OF IRVING**  
**1300 Walnut Hill lane, Suite #200**  
**Irving, Texas 75038**  
**972-550-8369**

STAFF:

Craig W. Spillman, Ph.D., L.P.C., L.M.F.T., N.C.C.  
Maria Hankey, M.S., L.P.C. Intern  
James Larson, M.A., L.P.C. Intern  
Student Interns

Welcome to the Counseling Institute of Irving:

The following information is to ensure your understanding of our policies and procedures. If you have any questions, please feel free to ask for clarification from your therapist.

1. By signing this document I give my permission to be treated by a therapist at the Counseling Institute of Irving. I do this of my own free will. I recognize that there is no guarantee expressed or implied that my situation/condition will be alleviated by consulting a therapist at the Counseling Institute of Irving and that in some cases my situation/condition may be exacerbated particularly in the event that I terminate my treatment prematurely or against the professional advice of my therapist. I understand that I am entering into a professional relationship with my therapist and that no other relationship will exist between therapist and client during treatment or for a minimal two years post treatment

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Initials

2. I have been informed that the Counseling Institute of Irving functions under the ethical codes of the Texas State Board of Examiners of Professional Counselors and the ethical code of the Texas State Board of Examiners of Marriage and Family Therapists. The address and phone number for each licensing board are displayed in the waiting room.

\_\_\_\_\_  
Initials

3. I understand that all counseling sessions and records are confidential. No information can or will be released without written consent except in the cases of: child abuse; potential suicide; potential homicide; and court ordered subpoena.

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Initials

4. I understand that using a managed care company significantly decreases confidentiality and that my therapist has no choice but to report summaries and, at times, complete details to a case worker at the insurance company.

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Initials

5. I understand that each session will last 45 minutes; that each session is scheduled in advance and that in the event I do not cancel my scheduled appointment with 24 hours notice that I will be charged the regular fee for that session. I have been informed that the Counseling Institute of Irving has a 24 hour answering service that I may use at any time to cancel my appointment or in the event of an emergency.

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6. I have been informed that I NOT my insurance company, am fully responsible for paying my fee upon demand whether or not my insurance company makes a payment. Additionally, I have been informed that the Counseling Institute of Irving employs and outside collection agency and attorney for the purpose of collection of delinquent accounts. A minimal late fee of \$25.00 will be charged if your account has to be sent to collection and a reasonable late service fee and attorney's fee will be assessed to you should your account be forced into collection.

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Initials

7. I have been informed that there is not smoking allowed at the Counseling Institute of Irving due to the City of Irving fire codes. I have been informed that no unattended children are to remain in the waiting room. I have been given the opportunity to discuss these policies and procedures with my therapist and to ask any questions.

\_\_\_\_\_  
Initials

Signature: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Visa/MasterCard Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_ TX Drivers License #: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred By: \_\_\_\_\_

The office fee is \$150.00 per 45 minute session. As with any professional service payment is expected at the time services are rendered unless specific arrangements have been made with your therapist indicating otherwise. If your insurance carrier covers outpatient mental health care and you wish to take advantage of your benefits, please bring a COMPLETED insurance form to your session. **Be advised that YOU**, not your insurance carrier, are responsible for paying the fee. You will be billed for the full outstanding amount if your insurance company does not pay within 90 days of your session.

**CANCELATION POLICY:** In the event that you must cancel a scheduled appointment you are expected to give at least 24 hours notice to this office. We have a 24 hour answering service for your convenience. Failure to give 24 hours notice of a cancellation will result in full payment expected due to the untimely missed session.

My signature below acknowledges that I have fully read, fully understand, and agree to the above terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_